NAME:	MEDICAID ID:
DOB:	PRIMARY CARE GIVER:
GENDER:	PHONE:
DATE OF SERVICE:	INFORMANT:

12 MONTH VISIT CHILD HEALTH RECORD

HISTORY

☐ See new patient history form

INTERVAL HISTORY:
☐ NKDA Allergies:

Current Medications:

Visits to other health-care providers, facilities:

Parental concerns/changes/stressors in family or home:

Psychosocial/Behavioral Health Issues: Y ☐ N ☐
Findings:

☐ TB questionnaire, risk identified: Y ☐ N ☐
**TB skin test if indicated* ☐ PPD placed
(See back for form)

☐ **DEVELOPMENT:**
- Gross and fine motor development
- Communication skills/language development
- Self-help/care skills
- Social, emotional development
- Cognitive development
- Mental health

NUTRITION*:
☐ Breastmilk
Min per feeding: _____ Number of feedings in last 24 hrs: _____
☐ Formula (type) _____
Oz per feeding: _____ Number of feedings in last 24 hrs: _____
Water source: _____ fluoride: Y ☐ N ☐
☐ Solids _____

**See Bright Futures Nutrition Book if needed*

IMMUNIZATIONS

☐ Up-to-date
☐ Deferred - Reason:

Given today: ☐ DTaP ☐ HAV ☐ HBV ☐ HIB ☐ IPV
☐ MMR ☐ Pneumococcal ☐ Varicella ☐ MMR-V
☐ HIB-HBV ☐ DTap-HIB ☐ DTaP-HB-IPV
☐ DTaP-IPV-HIB ☐ Influenza

LABORATORY

☐ Up-to-date
☐ Deferred - Reason:

Given today: Hgb/HCT: Y ☐ N ☐ Results: _____
Lead screen: Y ☐ N ☐ Results: _____
Other: _____

Signature/title

UNCLOTHED PHYSICAL EXAM

☐ See growth graph

Weight: _____ (_____%) Length: _____ (_____%)
Head Circumference: _____ (_____%)
Heart Rate: _____ Respiratory Rate: _____
Temperature: _____

☐ Normal (Mark here if all items are WNL)

Abnormal (Mark all that apply and describe):

☐ Appearance	☐ Nose	☐ Abdomen
☐ Head/fontanels	☐ Mouth/throat	☐ Genitalia
☐ Skin	☐ Teeth	☐ Extremities
☐ Eyes	☐ Neurological	☐ Back
☐ Ears	☐ Heart/pulses	☐ Musculoskeletal
	☐ Lungs	☐ Hips

Abnormal findings:

Additional:
Teeth # _____

Subjective Vision Screening: P ☐ F ☐
Hearing Checklist for Parents: P ☐ F ☐
(See back for form)

HEALTH EDUCATION/ANTICIPATORY GUIDANCE *(See back for useful topics)*

☐ Selected health topics addressed in any of the following areas*:
- Family Interactions
- Nutrition
- Setting Routines
- Safety
- Development/Behaviors

ASSESSMENT

PLAN/REFERRALS

Dental Referral: Y ☐
Other Referral(s)

Return to office:

Signature/title

Name: Medicaid ID:

Typical Developmentally Appropriate Health Education Topics

12 Month Visit

- Begin weaning from bottle/breast to cup
- Discipline constructively using time-out for 1 minute/ year of age
- Encourage supervised outdoor play
- Establish consistent limits/rules and consistent consequences
- Limit TV time to 1-2 hours/day
- Praise good behavior
- Promote language using simple words
- Provide age-appropriate toys
- Provide favorite toy for self-soothing during sleep time
- Read books and talk about pictures/story using simple words
- Use distraction or choice of 2 appropriate options to avoid/resolve conflicts
- Make 1:1 time for each child in family
- No bottle in bed
- Provide nutritious 3 meals and 2 snacks; limit sweets/ high-fat foods
- Empty all buckets containing water
- Home safety for fire/carbon monoxide poisoning, stair/window gates, electrical outlet covers, cleaning supplies, and medicines out of reach
- Lock up guns
- Provide safe/quality day care, if needed
- Supervise within arm's length when near water/do not leave alone in bath water
- Use of front-facing car seat in back seat of car if >20 pounds
- Establish consistent bedtime routine
- Establish routine and assist with tooth brushing with soft brush twice a day
- Maintain consistent family routine
- Provide nap time daily

**See Bright Futures for assistance*

HEARING CHECKLIST FOR PARENTS

	Yes	No	
Ages 10 to 15 months	☐	☐	Does your baby give you toys or other objects (bottle) when you ask, without your having to use a gesture (holding out your hand or pointing)?
	☐	☐	Does your baby point to familiar objects if you ask ("dog," "light")?

If you answered "no" to any of the above questions, ask your doctor about a hearing test for your baby. Babies can be tested as soon as the day of birth.

TB QUESTIONNAIRE Place a mark in the appropriate box:	Yes	Do not know	No
Has your child been tested for TB?	☐	☐	☐
If yes, specify date			
Has your child ever had a positive TB skin test?	☐	☐	☐
If yes, specify date			
TB can cause fever of long duration, unexplained weight loss, a bad cough (lasting over two weeks), or coughing up blood. As far as you know:			
has your child been around anyone with any of these symptoms or problems? or	☐	☐	☐
has your child had any of these symptoms or problems? or	☐	☐	☐
has your child been around anyone sick with TB?	☐	☐	☐
Was your child born in Mexico or any other country in Latin America, the Caribbean, Africa, Eastern Europe, or Asia?	☐	☐	☐
Has your child traveled in the past year to Mexico or any other country in Latin America, the Caribbean, Africa, Eastern Europe, or Asia for longer than 3 weeks?	☐	☐	☐
If so, specify which country/countries?			
To your knowledge, has your child spent time (longer than 3 weeks) with anyone who is/has been an intravenous (IV) drug user, HIV-infected, in jail or prison, or has recently come to the United States from another country?	☐	☐	☐